Pediatric Case Management (CM) Plan for CIS Maternal Child & Family Health Services Prior Authorization

☐ Initial ☐ Renewal Date: ___/___/__ If renewal, STOP date of most recent Case Management Plan ___/___/___

Name (child)_____**(mom)**_____ **DOB** _____ **Medicaid #**_____

Address_____ **Phone** _____ **Health Provider** _____

Lead CM Agency:_____Medicaid Provider #: _____
Collaborating CM Agency: _____ Medicaid Provider #:_____

→ Is a family member receiving Medicaid-funded home-based and/or Case Management Services from another program? ___Yes ____No
If yes, check all that apply: ____ECFMH ____DDMHS ____Part C ____Family Services ____Economic Services_____Other (please specify)
If yes, CM Plan below must show that CM services requested do not duplicate Medicaid–funded services of other programs.

ASSESSMENT - If renewal, include progress made under prior plan

Family Strengths:

Family Risks:

- ☐ Significant medical problems (preterm, LBW, SGA/IUGR, hospitalized, FTT, congenital anomalies, chronic disease)
- ☐ Medical/environmental risk for development delay (five domains)
- ☐ Problems with feeding; inadequate diet
- ☐ Parent has unrealistic expectations of infant/lack of attachment
- ☐ Family is isolated; not utilizing community resources; absence of social supports
- ☐ Parent age 17 or younger
- ☐ Parent with significant cognitive delays/mental illness
- ☐ Domestic violence/abuse in household
- ☐ Child abuse/neglect (current or child history and not removed from home)
- ☐ Tobacco/alcohol/drug abuse (current use by parents)
- ☐ Homeless, unsafe housing
- ☐ Other _____

PLAN - Not to exceed six month time period

Short Term Goals

Goal (Objective)	Action Plan (Activities)
1	1 a)
	b)
2	2 a)
	b)
3	3 a)
	b)

Long Term Goals: CIS; 1) all children have a medical and dental home; 2) children's growth and development are on target; 3) parents, families and caregivers help their children develop and learn; 4) families have the supports they want and need; 5) families know their rights and advocate effectively for their child

CM Agency Use Only CM Time Period Requested:				**VDH Use Only** CM Time Period Approved:
Start: / / Stop : / / (# of wks) ___				Start: / / Stop: / / (# of wks)___
✓	**HBK&F Procedure Code**	**HHA or PCC (Circle)**	**# of Visits Requested**	**# of Visits Approved**
	Birth to One T1022-HA-U6 (RN/MP-HHA/LR)	HHA Only		
	Birth to One T1022-HA-U7 (RN/MP-HHA/HR)	HHA Only		
	Birth to One S9445-HA (FSW/LR)	HHA PCC Other		
	Birth to One S9445-HA-U7 (FSW/HR)	HHA PCC Other		
	Birth to One S9445-HA-U6 (MP-FSW/HR)	HHA PCC Other		
	1 - 5 T1022-HA-TF (RN/MP-HHA/HR)	HHA Only		
	1 - 5 S9445-HA-U7-TF (FSW/HR)	HHA PCC Other		
	1 - 5 S9445-HA-U6-TF (MP-FSW/HR)	HHA PCC Other		
(MP-Masters prepared LR – low risk HR – high risk)				Date Data-Entered: ____/____/____
CM Signature: Date Signed: ___/___/___				**VDH/MCH Coordinator:**
Collaborating CM Signature:				___Approved ___App w/ change ___Deny